VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

August 14, 2014

Mr. Dane Rank, Administrator
Thompson Residential Home
80 Maple Street Po Box 1117
Brattleboro, VT 05302-1117

Dear Mr. Rank:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 7, 2014.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:jl

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0156	A. BUILDING: _____ B. WING _____	C 07/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMPSON RESIDENTIAL HOME	80 MAPLE STREET PO BOX 1117 BRATTLEBORO, VT 05302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site complaint investigation was conducted on 7/7/14 by the Division of Licensing and Protection. This investigation was in conjunction with a complaint at the Nursing Home that is housed with the Residential Care Home. There were findings with the investigation and the findings include:	R100		
R136 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to annually assess 3 out of 3 residents reviewed and to assess Resident #1 with a change in the resident's physical or mental condition. Findings include: Resident #1 was admitted to the facility 7/30/12 and on 7/7/14 record review conducted, there was no evidence of an annual assessment being completed and no assessment secondary to documented changes in mental condition. Per Registered Nurse, there was verification that there were no assessments. The administrator confirmed that there is no evidence of assessments being conducted for Resident #1. Also reviewed 2 other residents on the Residential Care Unit to find no evidence in those	R136	R136 5.7.c Assessment completed for Residents #1. Assessment placed in Resident #1 record. All records reviewed to ensure assessments are completed. Audits will be completed quarterly by DNS or designee to ensure that assessments are complete. Results will be reported at QA meetings. R136 POC accepted 8/13/14 BBartell RN/PMC	5/18/14 7/8/14 8/18/14 Ongoing Ongoing

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R136	Continued From page 1 records of assessments being completed. Per the administrator, h/she thought they may be in the process of being revised, but was unable to provide evidence of the assessments and stated that h/she did not have access to them.	R136	R189 5.12.b (3) Significant Change Assessment completed for Residents #1. All records reviewed to ensure assessments are completed. Audits will be completed quarterly by DNS or designee to ensure that assessments are complete. Results will be reported at QA meetings. R189 POC accepted 8/13/14 BBorter RN/PMC	8/8/14 8/18/14 Ongoing Ongoing
R189 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (3) For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to have in the record of 3 residents an initial assessment; annual reassessment; and significant change assessment for Resident #1. Resident #1 was admitted to the facility 7/30/12 and on 7/7/14 record review conducted, there was no evidence of an annual assessment being completed and no assessment secondary to documented changes in mental condition. Per Registered Nurse, there was verification that there were no assessments. The administrator confirmed that there is no evidence of assessments being conducted for Resident #1. Also reviewed 2 other residents on the	R189		

Division of Licensing and Protection

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R189	Continued From page 2 Residential Care Unit to find no evidence in those records of assessments being completed. Per the administrator, h/she thought they may be in the process of being revised, but was unable to provide evidence of the assessments and stated that h/she did not have access to them.	R189	R208 5.18.c Assessment and Care Plan reviewed for Resident #1. Policies regarding Reporting of Abuse, Neglect or Exploitation reviewed and updated as necessary. DNS/Staff Development to inservice all staff regarding Reporting of Abuse, Neglect or Exploitation. Incidents and concerns will be reviewed by the DNS and/or Administrator to ensure timely Reporting of Abuse, Neglect or Exploitation. Results will be reported at QA meetings. R208 POC accepted 8/13/14 BBoardman/PMC	8/8/14 7/9/14 8/12/14 Ongoing Ongoing
R208 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to report allegations of verbal abuse directed to a resident that resides on the same floor in the nursing home section of the facility for 1 resident of 1 that was reviewed. Findings include: 1.) On 5/13/14 per nurse progress note, another resident again "lashed" out at Resident #1 and his/her spouse. Per interview with writer, h/she stated that it was not uncommon for that resident to yell at Resident #1. Registered Nurse states that h/she reported the incident to the Director of Nurses. At 7:30PM the administrator confirmed	R208		

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R208	Continued From page 3 that there were no reports filed with the State Agency regarding this incident. 2.) On 5/17/14 documentation presents that verbal abuse occurred between Resident #1 and his/her spouse. The spouse claimed that Resident #1 was hitting him/her. There is no evidence that the incident was reported and the administrator had said that there were no reports filed with the State Agency regarding this incident. 3.) On 5/22/14 documentation presented that Resident #1 argued with spouse and called him/her foul names and the spouse made a statement that Resident #1 was dangerous. Again on 5/23/14 documentation supports that Resident #1 was verbally abusive to spouse. On 5/24 per nurse progress note, "Agitation toward [spouse] for about 2 hours at 3:30PM. This resolved itself." 6/1/14 documentation that resident was standing over spouse, waving finger and hollering at him/her. Progress note from 6/25 presents that Resident #1 was witnessed to be mean to spouse and that h/she was trying to purposefully run into things and then sitting with others and yelling at spouse. Verbal abuse also documented on 6/26, 28/14. On 7/1 Resident #1 continued to escalate and on 7/5/14 was witnessed to physically assault spouse. Per administrator none of the incidents were reported to the State Agency until the incident that occurred on 7/5/14 and h/she verified that it was not reported in a timely fashion or to the Police Department or State Agency as per regulations and the facility policy.	R208		